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SENATE REPUBLICAN POLICY COMMITTEE

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Senators Consider Innovations

Ideas to Transform American Health Care

Introduction

On April 25, 2007, the Senate Republican Policy Committee hosted a "Forward-Looking Dinner" discussion on health care. Republican Senators explored the problems of our health system and potential innovations with four guests: two academics and two business leaders.[1]

The two core problems with the American health care system, participants agreed, are that costs are skyrocketing, making health coverage less affordable, and that the quality of care provided – while excellent in some institutions and in certain regions – is not sufficient in many places. These problems hurt individuals, families, and employers, and they significantly limit America's competitiveness.

The innovative solutions proposed by attendees are rooted in the core Republican values of free markets, entrepreneurship, and individual choice. While health care is a special brand of economic good, targeted reforms can help market forces treat much of what ails American health care while maintaining a safety net.

After describing the basic problems and their underlying causes, this paper will examine how existing market-oriented health care efforts have thrived, and will describe possible reforms to promote those efforts and to help resolve these problems.

Background and Theory

There are many reasons for the high costs and inconsistent quality that plague the U.S. health system. The primary driver of these worsening problems is a system that promotes the inefficient provision of more and more health services – essentially, quantity over quality.

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[1] The four guests were Regina Herzlinger, professor at Harvard Business School; John Goodman, president of the National Center for Policy Analysis; Steve Sanger, CEO of General Mills; and Todd Stottlemyer, president of the National Federation of Independent Businesses.

Efficiency is a key goal in health care delivery. In fact, recent research showed that while the care at some of America's top medical institutions, such as the Mayo Clinic, is relatively expensive, if all Americans received the highly efficient, high-quality health care that is provided at that clinic, total health spending would actually decrease by 25 percent.[2] This is because efficient care for patients means healthier outcomes due to more prevention and fewer complications and errors, i.e., fewer and shorter hospital admissions and intensive care unit stays.

Market-oriented reforms cannot remove all inefficiencies, but they can address the underlying causes behind our system's basic cost and quality problems. Turning to market-oriented health reforms can ameliorate the inefficiencies in our system. When competition and consumer choice are allowed to work in health care, they have improved quality and lowered costs. Such reforms can address the underlying causes behind our system's basic cost and quality problems.

At the dinner, the Senators and their guests identified underlying causes, such as the perverse incentives created by the tax code's treatment of health care and the anti-competitive third-party-payer system it has fostered. Most consumers know how much a loaf of bread costs, and they certainly know fresh from stale. Why don't the consumers of health care services know how much their care costs or how its quality stacks up? In part, the answer lies in the economics truism that when a third party pays, it insulates consumers from costs, and thus allows for unintended negative effects to occur. In health care, the negative side effects have been getting worse for many years.

The unintended effects of a third-party-payer health system

Most Americans in the workforce today know of no other system for health care coverage than the one that has predominated in the United States for many years – the employer-provided system. Yet, it was not always this way. In the years before the Second World War, most people who could afford to buy coverage "self-insured" – they bought their own health insurance to protect them against the event of catastrophic illness or injury. But such policies generally would not cover routine doctor or hospital visits. In other words, they were buying insurance in its traditional sense – to protect themselves against an unlikely but unaffordable event.

But in the post-war years, employers became the dominant sponsors of health coverage: today, about 170 million Americans have private health plans, and over 90 percent are employer-sponsored.[3] This shift is largely due to the fact that the tax code allows employers to exempt from taxes whatever they spend on health benefits; also, employees pay no taxes on this portion of their compensation package.[4] Furthermore, only dollars spent by employers are tax-exempt – individuals who buy their own plans must spend after-tax dollars.[5]

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[2] John Wennberg, "The Care of Patients with Severe Chronic Illnesses: An Online Report on the Medicare Program," Center for the Evaluative Clinical Sciences, Dartmouth Medical School, 2006.

[3] America's Health Insurance Programs, "Sources of Health Insurance and Characteristics of the Uninsured: Updated Analysis of the March 2006 Current Population Survey," May 2007.

[4] Essentially the federal government subsidizes employer-sponsored health benefits.

[5] An exception is an individual's health spending over 7.5 percent of adjusted gross income.

These perverse incentives led to individuals seeking health coverage from employers, and also – because the employer tax exemption has no cap – to an employer trend of offering more expensive plans with comprehensive coverage (sometimes referred to as "Cadillac" plans). Such health plans, as the third parties intervening between consumers and providers (doctors, hospitals, pharmacies, etc.), were paying more and more of health costs, requiring consumers to pay less and less out of their pockets, even for routine care.

Indeed, the percent of total U.S. health spending paid by individuals dropped from 47 percent in 1960 to 23 percent in 1980 and to 13 percent in 2004.[6] Consumers in traditional comprehensive plans see only a fraction of the prices that providers charge. With little incentive to care about actual prices for services and procedures, it is very difficult for consumers to be smart shoppers for health care. As a result, there is very little demand for comparative information about provider prices or quality.

With consumers insulated, there is also very little competition for consumers' business – either by providers or by plans. Most employees can choose only from the plans their employers offer them. This has stifled innovation by both providers and by health plans and has kept them from developing more efficient systems. All of the above has contributed to traditional plan premiums rising at more than twice the rate of wages or inflation.

Examples of Market-Oriented Health Care

As opposed to the third-party-dominated health system we are accustomed to, market-oriented health care uses the power of competition and consumer choice to maximize efficiency and value in health care. Market-oriented health has been very successful in the areas in which it exists in America and abroad. This section provides some instructive examples of this innovative, non-traditional health care system:

- ***Walk-in Clinics:*** For-profit retail walk-in clinics have been burgeoning across the country. Often staffed by nurse practitioners,[7] they provide basic primary medical services like immunizations or burn treatments. Such clinics generally are not participants with third-party-payers and can hold down their costs by avoiding the associated administrative and regulatory burdens. Since consumers pay the clinics directly, the clinics must compete for their business. These clinics offer lower prices (often half) and more convenience than traditional physicians' offices, often located in popular shopping areas and staying open in the evenings and on weekends.[8]

- ***Vision Correction Surgery Centers:*** Vision correction surgery is generally not covered by third-party-payer plans, either. So, various providers compete for consumers directly,

[6] Centers for Medicare and Medicaid Services, "National Expenditures by Type of Service and Source of Funds: Calendar Years 2004-1960," 2006.
[7] Nurse practitioners have more training than registered nurses and in most states can prescribe medications, order lab tests, and make referrals.
[8] Phone interview with Devon Herrick, Senior Fellow, National Center for Policy Analysis, May 16, 2007.

advertising price and quality; private comparative quality rating guides have also been created. Indeed, competition helped drive prices down by over 25 percent between 2000 and 2005 with improved patient satisfaction and better technology.[9]

Both the walk-in clinics and vision surgery centers have thrived in part because alternative forms of health insurance plans – known as consumer-driven plans – have become increasingly popular and politically supported in the marketplace.

In a consumer-driven health plan,[10] the costs above a certain monetary amount per year (a $2,500 deductible, for example) are generally paid for by the plan. Preventive benefits like screenings and physicals are also covered – since these are particularly important for keeping patients healthy and thus keeping overall health costs low. The consumer-driven plan can still be a "third-party-payer" but has a minimal role compared to traditional comprehensive plans in which the plan is the driver and the consumer just rides along.

The premiums of consumer-driven plans cost significantly less than traditional plans; enrollees can use these savings for health or other important expenses. Also, premiums do not rise as quickly as those in traditional plans.[11] These reasons are partly why consumer-driven plans have been gaining popularity: over 12 million Americans were enrolled as of 2006. Furthermore, the number enrolled in health savings account (HSA) plans has grown rapidly from 3.2 million in 2006 to 4.5 million in 2007.[12] HSA plans are consumer-driven plans that include savings accounts into which consumers and employers can contribute tax-exempt dollars to be spent on health expenses. The accounts are owned by consumers and are permanent and portable (retained even if they lose their job or find a different employer).

Many observers expect that as more consumers discover and buy consumer-driven plans, there will be more and more "smart shoppers" seeking lower prices and forcing traditional providers to compete for their business.

- ***The Federal Example – Medicare Part D:*** The Medicare Part D prescription drug benefit, while a large entitlement program, is achieving great savings over anticipated costs because it incorporates the consumer-driven health concepts of competition, transparency, and entrepreneurship. The Federal program permits a great deal of freedom for plans to design their benefits, resulting in a variety of offerings for seniors to compare and annually choose the best plans for their individual needs. As a result, over 80 percent of enrollees are satisfied with the program and are saving an average of $1,200 per year

[9] *Wall Street Journal*, "Lasik Lessons," March 10, 2006.
[10] Consumer-driven health plans, for this paper, consist of health savings accounts, health reimbursement accounts, and high-deductible health plans.
[11] According to an article in *Health Affairs* (September 26, 2006), since 2001, health insurance premiums have risen 68 percent. Also, between 2005 and 2006, certain types of consumer-driven plans had premium increases of 4.8 percent whereas traditional comprehensive plans increased by more than 8 percent.
[12] America's Health Insurance Plans, "January 2007 Census Shows 4.5 Million People Covered By HSA Health Plans," press release, April 2, 2007. (Note: 27 percent of new HSA enrollees were previously uninsured, according to AHIP.) For more information on HSAs, see earlier RPC paper, "Health Savings Accounts: Defying Critics' Dire Expectations," May 5, 2006.

on their drug expenses. In addition, they are being smart shoppers and are choosing less costly generic drugs more often.[13]

The Part D program is saving money for seniors and taxpayers and is providing a wide choice of high quality benefits – in short, the innovative program is demonstrating that market-oriented principles can work on a national basis in the United States.

- ***The International Example – the Swiss System:*** Switzerland has had extensive experience with market-oriented health care, and attains quality comparable to America's highest-quality settings. Every Swiss is required to purchase his own private health coverage, including the poor (who receive government subsidies). The key distinguishing elements of the Swiss system are that it is almost completely private and that the private health plans have more freedom and flexibility to innovate and compete. This has resulted in many competing plans offering various choices and transparent comparative information to help consumers choose wisely. Some plans offer lump-sum cash awards for those who stay healthy for five years or lower premiums for those who lose weight; some impose penalties for unhealthy lifestyles like smoking. Interestingly, in order to keep the system stable, these private plans "risk-adjust" each other: plans with healthier enrollees actually compensate plans with sicker enrollees. This removes the incentive for plans to "cherry pick" and encourages providers and plans to work to keep people healthy and save money.

Why should policymakers study the Swiss model? The Swiss spend only 11 percent of GDP on health and have significantly better health outcomes than the United States (which spends 17 percent of GDP on health).[14] Third parties (government, employers) pay much smaller percentages of the health spending in Switzerland – with better results.

Promising Ideas for Policy Reforms

The attendees at the dinner acknowledged that, while there is no single policy solution, policymakers should encourage market-oriented principles in health care.

Defined Contributions

One idea is to encourage employers toward defined contributions, in which employees select and purchase the best plans for themselves using the dollars the employer would have spent to cover the employee under an employer-sponsored plan. Employers would be encouraged to help their employees select and purchase the plans. One valuable benefit of such a shift would be that consumers will be able to keep their own portable coverage, regardless of where and whether they are working.

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[13] Centers for Medicare and Medicaid Services, "Generic Drug Utilization On the Rise: Consumers and payers benefit as more Americans turn to generics as a way to save money and improve their health," press release, February 8, 2007.

[14] Regina Herzlinger, "Consumer Directed Health Care: Lessons from Switzerland," *Journal of the American Medical Association*, September 8, 2004.

The perverse incentives in the tax code have led to the unintended effect of employers taking on bigger health obligations that are now burdening them and their employees. There are different ways to address these incentives and their unintended consequences – including tax deductions for individuals (as President Bush has proposed along with a cap on the employer tax exclusion[15]) or tax credits. But even if the tax code is changed, the shift from traditional employer-based plans would take time. People would initially be hesitant to self-insure just as there was initial skepticism 30 years ago when employers began shifting from pensions to 401(k) plans, which are now ubiquitous. Advisory services from employers as well as the public and private sectors would arise to help smooth the transition; this happened with the 401(k) shift as well.

Various states are considering defined contributions for their own over-burdened health plans – their Medicaid programs. For example, states such as Oklahoma and Florida are shifting toward directly giving Medicaid beneficiaries the funds to purchase the private health plan of their choice (allowances would be adjusted upward for sicker people) and contributing into lifetime savings accounts that beneficiaries can use to buy more coverage or for out-of-pocket health expenses.[16] Again, advisory services and beneficiary counseling is a key element of such proposals. These changes will enhance the Medicaid safety net for low-income Americans and give them more and better choices.

Price and Quality Transparency

Another idea is to encourage the availability of more comparative health care price and quality information for consumers. Consumers can utilize this information to adequately compare plans to help decide whether to self-insure, or whether to stay with a traditional comprehensive plan or shift to a lower-cost consumer-driven plan. As consumers shift toward paying their health costs directly, they will become smarter, more price-sensitive shoppers. For example, a consumer may wish to compare how given plans or hospitals treat diabetics and what such services cost consumers.

Such information has not been readily available in the past, but with the expansion of consumer-driven health care, such information will only become more available and consumer-friendly, and plans will have incentive to be more competitive.

Government can play a role in encouraging plans and providers to make more and better information available. The Bush Administration is already encouraging employers to demand more transparency from their plans and providers, starting with the nation's largest employers. The Administration also is demanding more transparency from providers participating in government health plans (such as Medicare and the Federal Employees Health Benefits Plan).

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[15] See RPC Policy Paper, "Summary of President Bush's Health Tax Reform Plan," February 6, 2007: http://rpc.senate.gov/_files/020507HealthTaxReformSN.pdf.

[16] Regina Herzlinger, Senator Tom Coburn, "They'd Sooner Fix Medicaid," *Wall Street Journal*, May 18, 2006. Note: Oklahoma's proposal has been approved and is scheduled for implementation in 2008. Florida's proposal was implemented in two counties last year and is scheduled to expand this year.

Some propose that the government take a further step and require the publication of provider performance data. Another related idea is the possible establishment of an independent entity or agency to collect the aggregate price and quality data about different plans and providers – similar to what the Securities and Exchange Commission does with financial data about public companies (this could help allay proprietary concerns).

Health Entrepreneurs

The Swiss system has thrived because providers and plans are able to innovate and respond to consumers. In the United States, there are already some health entrepreneurs, such as the owners of walk-in clinics, and many with other market-oriented ideas. But their efforts are inhibited by various State and Federal practice restrictions.

For example, telephone medical consultations have become very helpful for patients (or parents) who need medical advice at night and on weekends and in areas where there are few doctors or clinics nearby. However, Internet consultations between a doctor in one state and a patient in another are generally prohibited unless a face-to-face meeting has occurred first.

Telephone and online medical consultation providers often take advantage of electronic medical records. But such technologies have been extremely slow to enter the medical marketplace even though they are commonplace for client service in other industries (accounting, for example). Only about 20 percent of doctors and about 25 percent of hospitals use electronic records – and fewer than 25 percent of doctors allow patients to email them.[17] These innovative services and practices would improve cost efficiency and patient choice – but providers are not paid to be innovative.

Currently, traditional health plans pay providers based on specific tasks completed; there are about 7,500 itemized medical tasks. This system was devised by the traditional Medicare fee-for-service program, the nation's largest health payer, which wields enormous influence over the way private health plans pay via regulations and administrative requirements. Some argue that this contributes to the "quantity over quality" problem in American health care.

Some entrepreneurial providers would like to package services in patient-friendly ways and at lower prices – for example, establishing a payment for the coordinated care of a cancer patient rather than individual payments for each service required. Providers would then have an incentive to keep patients healthier, saving money for all parties. Some also propose that providers should be paid more for treating sicker patients and that plans should cost the same for healthy and sick consumers – like in Switzerland, where certain innovative providers who focus on treating certain conditions are rewarded when they attract those types of patients and keep them healthy.

Under the Bush Administration, Medicare has made some promising strides in certain parts of the program. For example, some of the private Medicare Advantage plans incorporate some of the ideas above. As well, traditional Medicare has begun to develop pilot programs to

[17] John Goodman, "Perverse Incentives in Health Care,"*Wall Street Journal*, April 5, 2007.

test coordinated-care payments for chronic diseases, such as diabetes, kidney disease, and lung disease, and has incorporated some risk-adjusted payments.

Conclusion

Market-oriented health care innovations like consumer-driven plans and other individual-empowering ideas have improved choices, quality, and affordability for Americans. These are vital considerations for policymakers working to transform American health care.